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ABSTRACT

Although statistical patterns associated with suicide suggest that blacks should be the least likely to commit suicide, black men between the ages of 18-25 do not conform to this pattern. The suicide rate for black males in this age group, which approximates and sometimes surpasses the rate for their white male cohorts, is more than three times higher than the rate for young adult black women. Analysis of death rates from suicide per 100,000 adult black population residing in approximately fifty metropolitan areas reveal that: (1) the gap between the suicide rates of males and females has been widening in every region of the country except the West; (2) rates have declined among metropolitan black females in each region of the country; among black males, rates have declined in the West and North Central regions and increased in the South and the Northeast. (Author/RLV)

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A Demographic Analysis of Suicide Among Black Males

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All of the statistical patterns associated with suicide suggest that as urban residents, of lower than avergage per capita income, Blacks should be least likely to commit suicide. By and large, this is true. But Black men, 18-29 do not conform to this pattern. While suicide is not a leading cause of death among Blacks, it is the third leading cause of death among Black males (after accidents and homicides) in the 18-29 age group. Young Black men in this age group are three to four times as likely to commit suicide as young Black women of the same age (see Davis, 1978; 1979). Young adult Black males accounted for 27% of the Black suicides nationally between 1970 and 1975, while young adult Black females accounted for only 8.3% (Davis, 1978).

The rate of suicide among young adult Black men has risen over the past decade to the point of approximating and sometimes surpassing that of their White male cohorts, which are well above average. The rise has been greatest among Black males ages 20-24 (15%) and 25-29 (42%), (Davis, 1978). A striking increase in the incidence of Black male suicide for all but the oldest age groups can be clearly discerned in Table 1, which presents Black male rates at five year intervals for the thirty year period 1947-1977. Within the 20-24 age group the rate increased dramatically (195%) from 7.3 to 21.5 per 100,000. In the peak suicide age range of 25-29, the rate increased nearly 250%, 8.2 to 28.5 per 100,000 Black male population. Equally as dramatic is the 136% increase experienced by Black males 30-34 (9.5 to 22.5).

The data in Table 1 clearly indicate that the young Black male suicide rate has been rising steadily since the early sixties. Until then, the

the rate fluctuated with no clear discernable pattern. In the pre sixties era the highest Black male suicide rate was recorded among the oldest age groups. Generally the data in Table 1 indicate that in the most recent decade suicide has become a growing menace to young adult Black males. It is seen as particularly acute because in the Black community, there is the general belief that suicide is a female problem.

Table 2 presents age specific suicide rates by sex for Blacks residing in Standard Metropolitan Statistical Areas (SMSAs) for the period 1970-1975. A SMSA or Standard Metropolitan Statistical Area, consists of a county or group of counties having a city or twin city with a population of 50,000 or more together with adjacent counties which are metropolitan in character and economically and socially integrated with the central city. Although the trends discerned in Table 2 are not necessarily durable and permanent, they indicate that the Black suicide rate increased slightly (2%) over the six year period. Among Black males the suicide rate increased by 7%, whereas Black females experienced a sixteen percent decrease in their rate. Indeed, significant declines occur among metropolitan Black females at all but the oldest age levels. Consistent with our earlier finding, significant increases occurred among young Black males in their twenties. Within the 18-24 age group the suicide rate increased 13% (18 to 20 per 100,000) and 17% (23 to 27 per 100,000) in the peak age range 25-29. Young Black males experienced a 13% increase in their rate while the older Black male rate declined by five percent.

Metropolitan Trends

Metropolitan areas have always been regarded as locales where suicide in general and Black suicide in particular are most frequent. Indeed, the existence of Black male suicide rates that are consistently higher than

those for Black females in some of the nation's largest and most populated metropolitan centers is common place in the suicide literature. In Table 3, attention is focused upon approximately fifty of the largest metropolitan centers, primarily those with a Black population of 100,000 or more. Analysis of this data reveals that among Black males, the SMSAs accounting for the highest rates at the beginning of the decade--Pittsburgh (41.3) and Columbus (31.5) were not leading centers of Black male suicide by the middle of the decade. Indeed, significant decreases in both metropolitan areas' male rates (73% and 29%) were recorded. By 1975, Cincinnati, Nashville, and Buffalo, with rates of 38, 37, and 32 per 100,000 adult Black male population, emerged as frontrunners. In Cincinnati, Black male suicide increased by more than 150%; while Buffalo recorded the most dramatic increase, 376%. Nashville's Black male suicide rate increased by a modest 50% over the period.

The lowest Black male rates occur in the same SMSAs recording the lowest total rates (as expected). In 1970 rates of approximately 4.4 per 100,000 characterized Black males in Shreveport, Norfolk, and Charleston. Mobile, the SMSA with the lowest total rate, had a male rate of 3.7 per 100,000. By the mid 70's, Augusta (2 per 100,000) joined Mobile (4.4 per 100,000) in recording the lowest rates. The Augusta SMSA experienced a 60% decrease in its Black male suicide rate between 1970 and 1975, propelling the metropolis from its relatively low 1970 male rate of 5 per 100,000 into the status of the SMSA with the lowest Black male rate by 1975.

Turning to Black females, we find that the Richmond, Virginia SMSA emerges as a consistent "high risk" area for Black females; rates of 11.5 and 12.7 per 100,000 were recorded between 1970 and 1975, an

increase of 10%. The Los Angeles-Long Beach urban area distinguished itself by recording the highest Black female rate known to this investigator in 1970--18.3 per 100,000. By 1975, however, the rate had decreased 46% to a little under 10 per 100,000 adult Black female population. Charleston, the SMSA with the third highest female rate in 1970 (11 per 100,000) recorded no mortality among Black females by suicide in 1975. Cincinnati (10.9), Louisville (10.8), and Nashville (10.2), together with Richmond (11.5) per 100,000, are the SMSAs with the highest Black female rates in 1975. Cincinnati earns the title of the metropolitan area in which Blacks experienced the greatest risk of suicide in 1975. Earlier, attention was directed to the fact that the highest rates for both the total and male populations were found in Cincinnati. It is no surprise then, to find the second highest female rate in Cincinnati by 1975, an increase of 90% over the six years. The Nashville and Louisville SMSAs recorded more dramatic increases in their rates, but the actual number of suicides is relatively small at both points in time.

Looking at SMSAs with the lowest adult Black female rates, we find that no deaths from suicide among Black females occurred in four of the SMSAs in 1970 (Paterson, Columbia, Fort Worth, and Greensboro-Winston-Salem-High Point). Three others, New Orleans (1 per 100,000), New York and St. Louis (1.7 per 100,000) had extremely low rates. In 1975 the number of SMSAs with no Black female suicides increased to six, with Ft. Worth, Texas and Paterson, New Jersey, continuing to be metropolitan areas in which Black females are relatively immune from mortality due to self-destruction. Charleston, Fort Lauderdale, Baton Rouge, and Dayton represent the remaining four SMSAs. Although the Charleston SMSA had the third highest rate for Black females in 1970, the actual numbers involved

are relatively small. Similarly, the Fort Lauderdale, Baton Rouge and Dayton 1970 rates are based on relatively small numbers of Black female suicide. Indeed, the reduction of their rates to zero merely reflects the fact that from 1970 to 1975 the actual incidence of suicide decreased by two or three cases. Hence, Black females in these urban areas represent a traditionally low suicide-prone group.

What is more, of the 46 SMSAs in 1975, 13 had female rates of less than 2 per 100,000. In addition to the six mentioned above, Augusta, Norfolk, Jacksonville, Dallas, Mobile, Pittsburgh, and St. Louis are the most noticeable. In all of these SMSAs, rates were low in 1970.

The difference in relative rates by sex among Blacks in our sample of SMSAs reflects trends indicating that suicide is something that males continue to do better than females. Data in Table 3 indicate that the gap between the suicide rates of males and females has been widening among metropolitan Blacks. Since the beginning of the decade, the ratio of male to female suicide increased 18% in the South (from 3:1 to 4:1), 30% in the North Central region (from 3:1 to 4:1), and 46% in the North East (from 5:1 to 7:1). In the West, the ratio remained relatively constant at 2:1, reflecting the narrowest margin between the sexes in the country.

In 1970 suicides were most democratically distributed between the sexes in Los Angeles, Charleston, Milwaukee, Dayton, Mobile, Shreveport, Jacksonville, Augusta, and Charlotte. Black males exceeded their female counterparts in suicide rate by ratios ranging from 11:1 to 20:1 in Greensboro-Winston-Salem-High Point, Louisville, Ft. Worth, New Orleans, and Paterson. By 1975, there were only 3 SMSAs (Richmond, Charlotte, and Shreveport) in which suicide was democratically distributed. The highest differentials were found in Charleston, Fort Lauderdale, Dallas, Ft. Worth, Baton Rouge, Dayton, Pittsburgh, and Paterson. Clearly, a comparison of the SMSAs with the highest

differentials over the six years indicates that the ratio is most unequal in Ft. Worth, Texas, and Paterson, New Jersey. On the other hand, the gap between the sexes is narrowest in Charlotte, North Carolina and Shreveport, Louisiana.

Change Between 1970 and 1975

The interesting pattern of trends observed thus far can be further explored by focusing upon changes in metropolitan Black suicide during the first half of the seventies. The last column of Table 3 shows changes for each of the 46 SMSAs between 1970 and 1975. In the metropolitan South, overall SMSA rates remained relatively constant; rates increased slightly among males and declined by 11.6% among females. Twenty-one (46%) of the metropolitan areas experienced increases in their total rates, in comparison with 25 (54%) that decreased. The 1970 to 1975 changes were most pronounced in Columbia and Shreveport; the dramatic rises in their rates are of concern, but the actual numbers involved are relatively small. The most significant changes occur in Washington, Nashville, and New Orleans, where there has been marked increases in both rate and percentage of suicide over the six years. The respective rates of increase are 65, 66, and 47 percent. Using similar logic, the 65% decline in the Baton Rouge SMSA is more significant than the noticeable decreases in Charlotte and Augusta.

Among Southern Black males residing in metropolitan areas, large increases occurred in Charleston, Shreveport, Columbia and Norfolk. However, increases in Washington, Birmingham, Nashville, and Fort Lauderdale are of more substantive interest. For example, the suicide rate among adult Black males in the nation's capital rose from 14 per 100,000 in 1970 to 25 per 100,000 by 1975, an increase of 83%. Birmingham's rate increased by nearly 70%, and Black males experienced a fifty percent increase in Nashville and Fort Lauderdale.

The suicide rate decreased by slightly more than half in Richmond and Greensboro-Winston-Salem-High Point. Decreases of 60% in Augusta and 64% in Baton Rouge were the largest observed. In both instances, relatively few cases of suicide were involved, but the decline in Baton Rouge is more meaningful given the size of its rates. Moderate rates of approximately forty percent occur in Louisville, Atlanta, and Miami.

Looking at changes among Black females in the metropolitan South, the problem of small numbers is again encountered when attempting to explain dramatic increases. Black females simply do not have a high incidence of suicide. The large increases in Greensboro-Winston-Salem-High Point, Columbia, and Ft. Worth are statistical artifacts resulting from the fact that no female mortality due to suicide occurred among Blacks in these SMSAs in 1970. In four other SMSAs, Nashville, Louisville, Shreveport, and New Orleans, the number of Black female suicides is less than 5 in both time periods. For example, in 1970 there was only one recorded suicide among Black females in Nashville and Louisville. By 1975, the number increased to four in both SMSAs.

The most noticeable declines occur in Baton Rouge, Fort Lauderdale, and Charleston. In each instance, the number of Black female suicides decreased from less than five to zero, registering decreases of 100%. Fairly large declines (50-90%) are recorded in Dallas, Mobile, Birmingham, Jacksonville, Augusta, and Charlotte; however the actual numbers involved are small in both 1970 and 1975. Although the Black female suicide rate decreased by 54% in the Washington, DC metropolitan area, the actual number of suicides increased slightly (from 7 to 8) between 1970 and 1975. Increases in the Black female population over the six-year period account for this anomaly. Finally, during both periods no Black female suicides were recorded

in the Ft. Worth metropolitan area, distinguishing it as the Southern SMSA in which Black females are most immune from self-destruction.

Among Blacks residing in metropolitan areas of the North Central United States, suicide rates declined by 17% among the total adult Black population, by 30% among Black females, and 6% among Black males. Cincinnati and Detroit were the only SMSAs in which increases occurred for the total adult Black population, 124% and 45% respectively. The remaining metropolitan areas experienced declines ranging from a low of 3% in Chicago to a high of 66% in Columbus.

Gary and Indianapolis, along with Columbus, recorded the greatest declines in their total rates. Suicide rates declined by two-thirds in Columbus (18 to 6 per 100,000), slightly more than half in Gary, Indiana (16 to 7 per 100,000), and by approximately half in Indianapolis (11.6 to 6 per 100,000). A decrease of 40% occurred in Kansas City (12.6 to 7.7 per 100,000).

As noted earlier, Cincinnati, Ohio--the top ranking SMSA in 1975--recorded the most dramatic increase over the six year period. Among adult Blacks, the suicide rate more than doubled, from 10 per 100,000 in 1970 to 22 per 100,000 in 1975. In Detroit, the rate increased less dramatically, from 11.6 to 16.8 per 100,000. It should be noted that Detroit was also a leading center of metropolitan Black suicide in 1975.

The most dramatic changes among Black males occur in two of Ohio's largest metropolitan areas. The suicide rate increased 150% in Cincinnati (15 to 38 per 100,000), and decreased by three-quarters (31.5 to 8.6 per 100,000) in Columbus. The rate increased 62% (18 to 30 per 100,000) in Detroit

and declined approximately 50% in Gary (27 to 13 per 100,000). More moderate declines, 36 and 38 percent, occurred in Kansas City (18 to 38 per 100,000) and St. Louis (12 to 7 per 100,000).

Cincinnati and Detroit are clearly the metropolitan areas accounting for most of the increase in suicide among adult Blacks residing in the North Central region of the country. Hence, it is no surprise to find that the Black female rate increased 88% in Cincinnati (6 to 11 per 100,000). However, determining the metropolitan areas in which the most significant declines occur is more problematic: 9 of the SMSAs in 1970, and 7 in 1975, had Black female rates that were based on the less than five cases of suicide. What is more, of the 9 in 1970, six had noticeable declines in their rates by 1975. Dayton, for example, which had no Black female suicides in 1975, and only three cases in 1970, experienced a decrease of 100%. In fact, six of the 9 SMSAs had declines of 40% or more. Clearly a comparison of the SMSAs with noticeable decreases in their female rates reveals that none of the metropolitan areas experienced significant declines in their rates other than possibly Dayton, Ohio.

In the metropolitan Northeast, the pattern of change observed in the adult Black suicide rate is one of an increasing trend, though rates declined slightly among females. The exploration of changes by region indicates that, over the six-year span, adult Black males experienced the sharpest rises in their rates in the Northeast. Although the Black female rate declined, the drop is the smallest among all regions. Overall, rates increased nearly 50% among adult Blacks (9 to 13 per 100,000) between 1970 and 1975. As would be expected, Black males experienced the greatest increase --38% (19 to 26 per 100,000)--with the Black female rate decreasing 5%, from 3.8 to 3.5 per 100,000.

The most dramatic increases occur in the Buffalo SMSA, where the adult Black rate rose from 4.7 to 15.5 per 100,000, an increase of 230%. Black males living in this urban area experienced the greatest increase recorded among the 46 SMSAs (376%), from 7 per 100,000 in 1970 to 32 per 100,000 in 1975. Black female rates increased less sharply (70%), from 3 to 5 per 100,000; however, rates are based on less than five cases at both time periods. Similarly, the dramatic rise in rates among the total and male populations cannot be cited without reference to the relatively small number of actual cases of suicide occurring in 1970. For example, among adult Blacks, the frequency of suicide rose from 4 in 1970 to 10 in 1975. The increases in the Buffalo SMSA are worthy of attention; however, the actual numbers involved do not warrent the public concern implied by the magnitude of the change measures.

The New York metropolitan area recorded an increase of nearly 100% in the rate of Black female suicide. The rate rose from less than 2 per 100,000 in 1970 to 3.3 per 100,000 in 1975. This change represents a marked increase in actual cases of Black female suicide. The only instance of a decline in suicide rates for Blacks living in the metropolitan Northeast occurred in Newark, where the female rate declined by 35%, from 5.4 to 3.5 per 100,000 in 1975, and Pittsburgh where rates declined by 72%. As in Ft. Worth, Black females in the Paterson, New Jersey SMSA are relatively immune from suicide. No suicides occurred among Black females in either 1970 or 1975.

Boston, New York, and Philadelphia experienced moderate increases in both their total and male rates. Philadelphia, the SMSA with the second largest increase in the Northeast, experienced increases of 48% (10 to 14.5 per 100,000), and 73% (15 to 26 per 100,000), respectively. Adult Blacks living in New York had an increase in their rate of 44% (5 to 7.5 per 100,000),

with the Black male rate increasing 37% (10 to 13 per 100,000). In the Boston SMSA, total rates increased 43% (6 to 9 per 100,000), and Black male rates increased 49% (12 to 17 per 100,000). Finally, the Black male rate in Newark increased 58%, from 11 per 100,000 in 1970 to 18 per 100,000 in 1975.

As in the North Central region, suicide rates in the West declined for each category for which rates are shown. The bulk of the Black population residing in Western metropolitan areas lives in either the Los Angeles-Long Beach or San Francisco-Oakland SMSAs. Although rates decreased in both regions, the declines are generally sharpest among SMSAs located in the North Central United States.

The suicide rate declined 13% among all adult Blacks and males. The total rate decreased from 17.5 to 15 per 100,000 and the Black male rate moved from 24 to 21 per 100,000. The largest drop, 22% occurred among Black females. In 1970 their rate per 100,000 was nearly 13, but by 1975, the rate had slipped to 10 per 100,000 adult Black females.

Los Angeles-Long Beach, the Western SMSA with the sharpest drop in rates, recorded an overall rate decrease of 28% (21.4 to 15.5 per 100,000), whereas the San Francisco-Oakland rate decreased by only 6% (14.1 to 15 per 100,000). Declines in male rates are fairly similar in both metropolitan areas; 15% (25.3 to 21.5 per 100,000) in the former, and 11% (22.3 to 20 per 100,000) in the latter. Finally, Black females in the San Francisco-Oakland SMSA experienced a 15% (6.7 to 9.8 per 100,000) increase in their suicide rate; Los Angeles-Long Beach, on the other hand, recorded a 46% (18.3 to 9.8 per 100,000) decrease in rates of suicide among Black females.

Discussion and Conclusions

The foregoing analysis of the characteristics and trends of metropolitan adult Black suicide during the first half of this decade reveal that suicide within the Black community, as it is among Whites, is primarily a male problem.

The data indicate that students of suicide, mental health practitioners, and social commentators should direct their energies toward understanding the dynamics of what has become the third leading cause of death among young adult Black males in their twenties. Analysis of death rates from suicide per 100,000 adult Black population residing in approximately fifty metropolitan areas reveal that: 1) the gap between the suicide rates of males and females has been widening in every region of the country except the West; 2) rates declined among metropolitan Black females in each region of the country; among Black males, rates declined in the West and North Central regions and increased in the South and Northeast.

In general, male rates are higher than female ones and the difference varies from one metropolitan area to another. However, the sex ratio remained practically constant in the West, where males and females are equally exposed to factors producing suicide. The highest sex differentials are found in Ft. Worth, Texas, and Paterson, New Jersey, where no Black female deaths from suicide occurred. Since the beginning of the decade, the ratio of male to female suicide increased by nearly one-fifth in the South and by almost a third in the North Central region and approximately half in the metropolitan Northeast. Indeed the Black female suicide rate declined in every region of the country between 1970 and 1975. Changes among Black males, however, were not as consistent, displaying a mixture of trends.

The existence of Black male suicide rates that

that are consistently higher than those for Black females in metropolitan centers such as Greensboro-Winston-Salem-High Point, New Orleans, Louisville, Charleston, Fort Lauderdale, Dallas, Baton Rouge, Dayton, Pittsburgh, Ft. Worth, and Paterson, suggests that external circumstances are influencing one sex more than the other. Is it possible that Black females have a greater resistence

to suicide because of their higher participation rate and involvement in the traditional institutional structures, groups and relationships within the Black community (i.e., church, PTA, fraternal organizations, etc.)? This differential involvement may expose Black females to community support systems that provide participation and purpose, a sense of belonging, and the possibility of cooperative and self-help approaches to stressful situations that might otherwise lead to self destruction. Previous research by this investigator suggested a number of reasons for expecting a weakening of social relations to be strongly related to an increase in Black suicide. (Davis, 1978). Attention was focused upon the presumed detrimental consequences of becoming isolated (in part or entirely) from social support systems within the Black community, either at the family, group, communal, or institutional level. The results of this study suggest that improved social status (proxy-education) and isolation from protective social networks (proxy-migration) are strongly related to the increase in suicide among young (20-34) Blacks. Examination of recent research on the labor market position of young Black males and review of the established literature on the relationship between social mobility and isolation lends further support to this conclusion. Detailed investigation of the National Longitudinal Survey has found the occupational position of young Black men entering the job market after 1964 to be essentially the same as that of young Whites with similar pre-market background characteristics (Hall and Kasten, 1973). The 1973 Occupational Change in a Generation Survey has shown marked advances in the relative position of Blacks, particularly those aged 25-34, compared to the 1962 comparable survey (Hauser and Featherman, 1975). Several studies oriented toward other labor market problems have found that the traditionally large negative impact of being Black on economic status has become much smaller than in the past (Wilson, 1978; Viscusi, 1976; Epstein, 1977; Astin, 1978).

Hence, young talented, highly educated and skilled Blacks (primarily "prime-aged Black males" 20-44) were most likely to experience upward mobility via the social and economic progress of the sixties and early seventies. A fact that has probably not escaped the attentive reader, is that this prime-age range (20-44) corresponds to the age group in which the majority of Black suicides (mostly males) occur (20-34).

There is also an established body of literature that contends that social mobility results in isolation, or at least in the disruption of integration of primary and secondary group relations (cf. Durkheim, 1951; Sorokin, 1927; Janowitz, 1956; Blau, 1956; Litwak, 1960). The disruptive tendency of upward mobility for interpersonal relations received considerable attention from Blau (1956). He notes that:

> The upwardly mobile individual will have to give up old ties to gain status through association with higher-prestige groups and to avoid being identified with his former group. He may, however, find it difficult to establish extensive ties with individuals on the new level due to a reluctance on their part to accept him as an equal (Blau, 1956:290).

Hence, the Black community as a caring and protective system is likely to be less available to young upwardly mobile Black males. When these young Black males, because of racial differences, envy, personal crises, etc., begin to experience recurrent stressful social situations, they must do so without access to stable positive social networks within the Black community.

In addition to the young and upwardly mobile, less fortunate Black males who view their aged peers success as an indicator of their self worth (i.e. if they made it, I can make it) and internalize their failure and frustration and become isolated from their families, communities, and social institutions

increase their liklihood of self destruction. Thus it seems plausible to conclude that Black male suicide is best explained by institutional and sociological variables that highlight the character of institutions and the social patterns and networks that derive from them.

Table 1

Black Male Suicide Rates (per 100,000 Population), Selected Years

Age/Year	1947	1952	1956	1962	1967	1972[a]	1977	% Change 1947-1977
20-24	7.3	6.4	7.9	11.8	14.3	26.0	21.5	194.5
25-29	8.2	11.0	11.0	10.4	18.1	23.1	28.5	247.5
30-34	9.5	9.1	13.9	14.0	16.9	18.4	22.5	136.8
35-39	10.3	9.5	10.1	13.5	14.0	18.5	15.8	53.4
40-44	11.9	7.5	10.3	11.1	15.6	13.1	13.6	14.3
45-49	8.5	8.0	12.2	11.6	11.7	14.6	12.9	51.8
50-54	9.9	11.4	10.5	12.6	11.5	11.6	10.2	3.0
55-59	13.6	12.7	10.6	10.6	15.7	11.0	13.0	-4.4
60-64	14.0	15.8	12.9	18.9	10.4	12.9	12.4	-11.4

Source: Vital statistics of the United States, Volume II, mortality Part A (Published Annually), Mortality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics, Department of Health, Education, and Welfare.

[a] Rates for 1972 are based on a 50 percent sample of death certificates.

Table 2

Age Specific Suicide Rates

By Sex, Per 100,000 Metropolitan Black Population:

125 SMSAs,

1975, 1970 and Change

	1975	1970	Change
Both Sexes	9.9	9.7	2.1
All Males	16.7	15.6	7.1
18-24	19.8	17.6	12.5
25-29	27.0	23.0	17.4
30-34	20.8	21.6	- 3.7
35-39	16.0	15.4	3.9
40-44	12.6	11.9	5.9
45-49	11.9	18.2	-34.6
50-54	9.3	12.9	-27.9
55-59	8.3	10.7	-22.4
60-64	11.4	9.4	21.3
65 +	8.9	8.9	0.0
Young Males <35	22.4	19.8	13.2
Old Males >34	12.0	12.6	- 4.8
All Females	4.2	5.0	-16.0
18-24	4.2	6.8	-38.2
25-29	7.2	7.4	- 2.7
30-34	4.8	7.2	-33.3
35-39	4.3	5.0	-14.0
40-44	3.5	4.8	-27.1
45-49	2.9	4.4	-34.1
50-54	6.1	3.9	56.4
55-59	2.8	1.3	115.4
60-64	3.3	2.8	17.9
65 +	2.9	3.2	- 9.4
Young Females <35	5.1	6.8	-25.0
Old Females >34	3.6	3.7	- 2.7

Source: Computations by author from 1970 and 1975 Mortality Tapes and 1970 County Group Public Use Sample and 1976 Survey of Income and Education.

Table 3

Trends in Suicide Among Blacks in Metropolitan Areas[a], Rates per 100,000 Black Population[b] by Sex, 1970 and 1975 and Change for SMSA's by Region

Rank 970	Rank 1975	SMSA	1970 Both Sexes	1970 Males	1970 Females	1970 Ratio	1975 Both Sexes	1975 Males	1975 Female	1975 Ratio	Change Both Sexes	Change Males	Change Females
		SOUTH	8.7	14.2	4.3	3.3	8.9	15.0	3.8	3.9	2.3	5.6	-11.6
15	11	Baltimore MD	10.9	17.7	5.2	3.4	11.9	23.3	2.4	9.7	9.2	31.6	-53.9
23	9	Washington DC-MD-VA	8.0	13.8	3.0	4.6	13.2	25.3	2.8	9.0	65.0	83.3	- 6.7
9	17	Richmond VA	14.0	17.1	11.5	1.5	10.4	8.0	12.7	0.6	-25.7	-53.2	10.4
37	35	Norfolk-Portsmouth VA	* 3.1	* 4.3	* 2.0	2.2	5.3	9.4	* 1.6	5.9	71.0	118.6	-20.0
27	38	Greensboro-Winston Salem-High Point NC	7.0	15.8	0.0	15.8	4.6	*6.6	*3.2	2.1	-34.3	-58.2	320.0 [c]
26	37	*Charlotte NC	7.3	8.0	6.8	1.2	4.9	7.3	2.9	0.9	-86.5	- 8.8	- 57.4
34	18	*Columbia SC	4.1	8.3	0.0	8.3	9.5	18.3	2.8	6.5	131.7	120.5	280.0 [c]
32	41	*Augusta GA	4.8	5.0	4.6	1.1	1.2	2.0	0.5	4.0	-75.0	-60.0	- 89.1
23	21	Charlestown SC	* 8.0	* 4.4	*11.0	0.4	8.5	17.3	0.0	17.3	6.3	293.2	-100.0
22	32	Jacksonville FL	8.6	*10.1	* 7.5	1.3	6.2	11.1	* 1.5	7.4	-27.9	9.9	- 80.0
19	12	*Fort Lauderdale-Hollywood FL	* 9.8	*16.0	* 4.6	3.5	11.6	23.9	0.0	23.9	18.4	49.4	-100.0
17	29	Miami, FL	10.3	14.8	* 6.7	2.2	6.7	9.3	* 4.1	2.3	-35.0	-37.2	- 38.8
10	8	Tampa-St Petersburg FL	13.4	22.1	* 6.1	3.6	14.4	*22.0	* 8.5	2.6	7.5	- 0.5	39.3
9	14	Atlanta GA	14.0	24.6	5.8	4.2	10.9	15.8	6.9	2.3	-22.1	-35.8	19.0
22	15	Birmingham AL	8.6	12.8	* 5.5	2.3	10.8	21.5	* 2.7	8.0	25.6	68.0	- 50.9
25	28	Memphis TN-AR	7.6	11.8	* 4.5	2.0	6.9	12.3	2.0	6.2	- 9.2	4.2	0.0
11	2	Nashville-Davison TN	13.2	25.0	* 3.1	8.1	21.9	37.4	*10.2	3.7	65.9	49.6	229.0
6	6	Louisville KY-IN	15.5	32.2	* 3.0	10.7	14.8	19.6	*10.8	1.8	- 4.5	-39.1	260.0
26	30	Dallas TX	7.3	9.6	* 5.3	1.8	6.5	12.5	* 1.0	12.5	-11.0	3.0	-81.0

Rank 1970	Rank 1975	SMSA	1970 Both Sexes	1970 Males	1970 Females	1970 Ratio	1975 Both Sexes	1975 Males	1975 Females	1975 Ratio	Change Both Sexes	Change Males	Change Females
20	26	*Ft. Worth TX	8.9	20.0	0.0	20.0	7.4	18.2	0.0	18.2	- 1.7	- 9.0	0.0
35	16	*Shreveport LA	3.7	4.3	3.3	1.3	10.7	*11.8	* 9.5	1.2	189.0	174.0	188.0
30	34	*Jackson MS	6.1	8.8	3.8	2.3	5.6	7.7	3.9	2.0	- 8.2	-12.5	2.6
36	40	*Mobile AL	3.6	3.7	3.6	1.0	2.7	4.4	1.2	3.7	-25.0	18.9	- 66.7
7	36	Baton Rouge LA	14.7	28.2	* 3.8	7.4	* 5.2	*10.1	0.0	10.1	-64.6	-64.2	-100.0
24	13	New Orleans LA	7.8	16.7	* 1.0	16.7	11.5	21.5	* 3.0	7.2	47.0	29.0	200.0
28	22	Houston TX	6.8	10.8	* 3.4	3.2	8.2	13.4	3.7	3.6	21.0	24.1	8.8
		NORTH CENTRAL	12.1	18.5	6.4	3.0	10.1	17.4	4.5	3.9	-16.5	- 5.9	- 30.0
13	33	Indianapolis IN	11.6	17.1	* 7.0	2.4	5.9	*10.1	* 2.2	4.6	-49.1	-40.9	- 68.6
18	1	Cincinnati OH	9.9	15.1	* 5.8	2.6	22.2	38.0	10.9	3.5	124.2	151.7	87.9
16	23	Dayton OH	10.8	*12.0	* 9.9	1.2	8.1	16.7	0.0	16.7	-25.0	39.2	-100.0
3	31	Columbus OH	18.4	31.5	* 3.9	8.1	6.3	* 8.6	* 4.5	1.9	-65.8	-72.7	15.8
5	6	Cleveland OH	16.0	25.6	8.4	3.1	14.8	24.3	6.1	4.0	- 7.5	- 5.3	- 27.4
13	3	Detroit MI	11.6	18.3	5.8	3.2	16.8	29.6	7.2	4.1	44.8	61.8	24.1
21	21	Chicago IL	8.8	15.2	3.6	4.2	8.5	15.0	3.6	4.2	- 3.4	- 1.3	- 14.3
4	27	Gary IN	16.2	27.4	* 6.2	4.4	* 7.3	*12.7	* 3.2	4.0	-54.9	-53.7	- 48.4
14	17	Milwaukee WI	11.1	*11.6	*10.6	1.1	9.6	17.1	* 2.6	6.6	-13.5	-47.4	- 75.5
12	24	Kansas City MO-KS	12.6	18.0	* 8.3	2.2	7.7	11.6	* 4.0	2.9	-38.9	-35.6	- 51.8
20	39	St. Louis MO-IL	6.1	12.0	* 1.7	7.1	4.2	7.4	* 1.4	5.3	-31.2	-38.3	- 17.7
		NORTH EAST	9.0	18.9	3.8	5.0	13.0	26.1	3.6	7.3	44.4	38.1	- 5.3
29	20	Boston MA	6.3	*11.7	* 2.2	5.3	9.0	17.4	2.3	7.6	42.9	48.7	4.6
33	4	Buffalo NY	* 4.7	* 6.7	* 3.0	2.2	15.5	31.9	* 5.1	6.3	229.8	376.1	70.0
31	25	New York NY	5.2	9.8	1.7	5.8	7.5	13.4	3.3	4.1	44.2	36.7	94.1
1	10	Pittsburgh PA	21.5	41.3	* 5.3	7.8	12.9	29.3	* 1.5	19.5	-40.0	-29.1	- 71.7

Rank 1970	Rank 1975	SMSA	1970 Both Sexes	1970 Males	1970 Females	1970 Ratio	1975 Both Sexes	1975 Males	1975 Females	1975 Ratio	Change Both Sexes	Change Males	Change Females
23	19	Newark NJ	8.0	11.3	5.4	2.1	9.4	17.8	3.5	5.1	17.5	57.5	- 35.2
25	20	*Patterson-Clifton-Passaic NJ	7.6	17.3	0.0	17.3	9.0	20.1	0.0	20.1	18.4	16.0	0.0
19	7	Philadelphia PA	9.8	15.3	5.4	2.8	14.5	26.4	6.1	4.3	48.0	73.0	13.0
		WEST	17.5	23.8	12.5	1.9	15.2	20.7	9.8	2.1	-13.0	-13.0	- 22.0
2	4	Los Angeles-Long Beach CA	21.4	25.3	18.3	1.4	15.5	21.5	9.8	2.2	-28.0	-15.0	- 46.0
8	5	San Francisco-Oakland CA	14.1	22.3	6.7	2.2	14.9	19.8	9.8	2.0	6.0	-11.0	15.0

Source: Computations by author from 1970 and 1975 Mortality Tapes and 1970 County Group Public Use Sample and 1976 Survey of Income and Education

* Rates based on less than 5 cases of suicide.

[a] Only SMSA's with 40,000 or more adult Black population in 1970 and 1975, and enough cases of suicide to allow the calculation of stable rates.

[b] Since suicide is rare under age 18, all Blacks below this age were excluded from the population of each SMSA. The rates then reflect suicide among adult Blacks 18 and above.

[c] These increases are statistical artifacts resulting from the fact that no Black female suicides occurred in 1970.

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